



**RBC
Insurance**

Disability and/or Critical Illness

Insurance Application

- **Use for all Disability and Critical Illness Insurance products.**
- **DO NOT use for Long Term Care Insurance. Instead, please use the Long Term Care Insurance application.**

IMPORTANT GUIDELINES

- **Print legibly in ink, preferably black for photocopy purposes. DO NOT use ditto marks.**
- **DO NOT make erasures or use liquid paper. Stroke out an error and have the applicant initial it.**
- **After the application has been signed, have additions initialed by the applicant. The application is a legal document forming part of the policy contract.**

Your Privacy Matters To Us

At RBC Life Insurance Company (RBC Insurance), we're committed to protecting your privacy. We respect your privacy and want you to understand how we safeguard your personal information.

How we collect your information

We collect and keep information about you, which is needed to provide the products and services you request. We collect information from you, either directly or through our representatives. We may also need to collect information about you from sources such as hospitals, doctors and other health care providers, the Medical Information Bureau, the government (including government health insurance plans) and other governmental agencies, other insurance companies, financial institutions, motor vehicle reports, and your current and former employer.

How we use your information

We use your information to provide the products and services you request, which includes using it to evaluate insurance risk and manage claims. We may also share your information with others who work for RBC Insurance or other RBC Financial Group® companies, or with third parties, when it is necessary for the services we provide to you. Third parties may include other insurance companies, the Medical Information Bureau, financial institutions, third party administrators, and any references you provide.

We may use your information internally, to prepare statistical reports that help us understand the needs of our customers and that help us understand and manage our business.

If you have given us your social insurance number, we will use it for taxation purposes and to help identify you with Citizenship and Immigration Canada, when necessary.

Please note that this paragraph is not applicable if this application is submitted by an independent representative or a representative who is attached to a firm other than RBC Insurance.

Other ways we use your information

When you request products and services directly from RBC Insurance, there are other ways we may use your information. For example, we may use or share some of your information to help you find out about other products and services from RBC Insurance and other companies of the RBC Financial Group. However, we will never use or share your health information for these purposes. To better manage your relationship with other companies of RBC Financial Group, and where the law allows us, we may consolidate the information we have about you with information held by the other member companies.

If, at any time, you decide that you do not want us to use your information as described here, under "Other ways we may use your information," please let us know by calling us at 1-800-663-0417.

Your right to access your information

You have a right to access the personal information that we have about you in your file. If we have information that is not correct, you can have it corrected.

To access your information or to ask us to correct information, you can contact us at:

RBC Life Insurance Company
1122 International Boulevard,
P.O. Box 5044,
Burlington, Ontario
L7R 4C1
Telephone: (888) 604-3434
Facsimile: (888) 349-7773

If you would like more information about client privacy

RBC Financial Group publishes a brochure on client privacy. If you would like a copy of the brochure, you can contact us and we would be pleased to send one to you.



APPLICATION COMPLETION TIPS

This Application may be used to apply for all policies. Ensure all questions are answered in full. If the Producer is present, the Producer Remarks section must be completed.

Policies issued by RBC Life Insurance Company

POLICY	INSTRUCTIONS
The Professional Series The Foundation Series Quantum	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. If this Application is part of a Wage Loss Replacement Plan, also complete page 15. If Minimum Payment is made, complete the Receipt and Conditional Insurance Agreement on page 12 and leave with the Proposed Insured.
Preferred Business Overhead Expense	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 16. If Minimum Payment is made, complete the Receipt and Conditional Insurance Agreement on page 12 and leave with the Proposed Insured.
Retirement Protector Business Loan Protector Key Person Protector	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. If Minimum Payment is made, complete the Receipt and Conditional Insurance Agreement on page 12 and leave with the Proposed Insured.
Critical Illness Recovery Plan	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 21. If Minimum Payment is made, complete the Application for Conditional Insurance on Critical Illness Application at the top of page 13 and attach to the Application. Leave the Conditional Insurance Agreement and Receipt on Critical Illness Applications with the Proposed Insured.
Bridge Series	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. If this is part of a Wage Loss Replacement Plan, also complete form W693 99C. (Copies are available at our offices). If Minimum Payment is made, complete the Receipt and Conditional Insurance Agreement on page 12 and leave with the Proposed Insured.
Disability Buy Sell	Complete pages: 1, 2, 3, 4, 5, 6, 7, 8, 9 and 10. If Minimum Payment is made, complete the Receipt and Conditional Insurance Agreement on page 12 and leave with the Proposed Insured.

- For your convenience a Back & Neck Disorder Questionnaire is located on pages 17 and 18, and a Nervous Disorder Questionnaire is located on pages 19 and 20.
- The Proposed Insured should retain the Consumer Fact Sheet located on page 14.
- Please use one colour ink, preferably black. Handwriting should be legible. Never type the Application. Do not use “white out”. Changes should be made using a single line cross-out and must be initialed by the applicant, not the Producer. The signature, date and income sections should never be altered.
- Explain unusual circumstances and offer additional information in the Producer Remarks section or a cover memo.



PART 1 (You/Your refers to the Proposed Insured.)

New Policy Policy Change Reinstatement

PROPOSED INSURED

(Check One) MR. MRS. MS. MISS DR.

- 1. PRINT Name as legally known
a. Last
b. First & Middle
c. Former Name
d. Birthdate: Mo. Day Yr. e. Age (nearest)
f. Birthplace: (Province/Country)
g. Sex: M F
h. Do You understand English or French? Yes No
i. Is a French language policy requested? Yes No
j. Canadian Citizen Permanent Resident Other (specify)

- 2. a. Residence address: Apt. No.
b. Street
c. City
d. Province e. Postal Code
f. Phone No.
g. How long have You resided in Canada? yrs.
h. Do You expect to change country of residence? Yes No
i. Premium notices to be sent to: Residence Business
If premium notices are to be sent to someone other than the owner/insured please complete Part 3E.

EMPLOYMENT INFORMATION

- 3. a. Occupation(s)
b. Professional Designation(s) or Degree(s)
c. Exact Duties (describe fully)
d. Breakdown of duties - Office Supervisory Manual Driving Travel (outside North America) Other (describe) Total = 100%
f. How many hours per week do You work?
g. What % of this time is spent working in Your home?
h. Is employment seasonal? Yes No
i. If "Yes", number of weeks worked per year.
j. Do You have any part-time or other full-time jobs? Yes No
k. If "Yes" describe exact duties, number of hours worked and income.
l. Do You expect to change jobs within the next 6 months? Yes No
m. If "Yes", describe

- 4. a. Business/Employer Name
b. Business/Employer Address: Suite No.
c. Street
d. City e. Postal Code
f. Province g. Phone no.
h. Nature of Employer's Business
i. Number of years in present business?
j. Number of years in similar business?
k. Are You an employee? Yes No
l. Are You a commissioned salesperson? Yes No
m. Are You self-employed? Yes No
n. If self-employed, number of years self-employed?
o. Number of full-time employees excluding owners?
Organization of business: sole owner partnership corporation
s. Percentage of ownership %
t. What is Your current business year end?

ADDITIONAL INFORMATION (Provide details to "Yes" answers below)

- 5. HAVE YOU ever: YES NO
a. Had life, disability or critical illness insurance rated, modified, rejected, cancelled, or been denied renewal or reinstatement?
b. Received, requested, or been refused disability, hospital, or medical benefits or a pension for any sickness or injury?
c. Received disciplinary action from Your licensing body and/or been charged or convicted with any criminal offence?
6. HAVE YOU: within the past five years:
a. Been charged with or convicted of any driving offences? If "Yes", give Driver's Licence No. and complete details below.
b. Declared personal or corporate bankruptcy? If "Yes", give discharge date & complete details below.
7. Collected E.I., workers' compensation benefits, or any form of social assistance in the past 12 months or prior calendar year?
8. a. Within the past two years engaged in: motorcycle riding, ATV use, scuba diving below 50 feet, bungee jumping, parachuting, karate, judo, hang-glider, motor vehicle or motorboat racing, rodeo activities, skiing, mountain climbing, snowboarding, or any other sport or avocation? If "Yes", complete appropriate Questionnaire.
b. Ever piloted a plane, ultralight or glider, or do You have any intention of doing same in the future? If "Yes", complete Aviation Questionnaire.

Details to "Yes" answers:

FINANCIAL INFORMATION

Net earned income is Your net income after all business expenses, before personal taxes. Do not include other sources of income such as E.I. Benefits, RRSP income, family allowance or any income which is not dependent on Your ability to work. Do NOT include PERKS. They will be included in the calculations at our office if Proposed Insured is eligible.

- 9. Your year to date net earned income for the current year is: \$ _____
- 10. Your net annual earned income, as declared on Your federal income tax return was:
 - a. Actual Last Calendar Year (specify year) (_____) \$ _____
 - b. Actual 2 Calendar years ago (specify year) (_____) \$ _____
- 11. If self-employed, do You income split for tax purposes? Yes No
- 12. If "Yes", what amount do You income split? \$ _____
- 13. Does Your annual unearned income exceed \$30,000? Yes No If "Yes", complete #15.
- 14. Does Your net worth (assets minus liabilities) exceed \$4,000,000? Yes No If "Yes", complete #16.

15. UNEARNED INCOME

- a. Net profit from rentals \$ _____
- b. Net realized capital gains \$ _____
- c. Unearned dividends \$ _____
- d. Interest \$ _____
- e. Other (describe) _____ \$ _____
- f. **TOTAL** \$ _____

16. NET WORTH

- a. Cash savings, stocks, bonds \$ _____
- b. Interest in Your business (excluding goodwill) \$ _____
- c. Personal property \$ _____
- d. Real estate (Residence only) \$ _____
- e. Other (describe) _____ \$ _____
- f. **TOTAL** \$ _____

EXISTING AND PENDING COVERAGE (Must be answered in all cases)

17. Describe **all** coverage in force. Include life and disability coverage under (A) individual, (C) association, (D) group LTD, (E) salary continuation or employer sick pay disability income coverage, (F) overhead expense, (G) buy-out, (K) key person, (L) business loan, (O) accident only, (R) critical illness, (V) government plans or other (specify) _____. **If none, write "None".**

Company	Issue Date	Life	Disability	Type of Coverage A, C, D etc. from above	Amount of coverage (e.g. monthly, lump sum)	Taxable Yes No	Elimination Period	Benefit period	To be Cont'd? Yes No	Replacement date
						<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>	
						<input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> <input type="checkbox"/>	

- 18. Have You applied for insurance concurrently or within the past six months with any other company? Yes No If "Yes", give details above.
- 19. Is policy applied for intended to change any existing insurance? Yes No If "Yes", give details above.
- 20. List the number of any policy in force with the Company. Indicate if it is to be an internal replacement (IR) or continued (Cont.). No. _____ (_____) No. _____ (_____) No. _____ (_____)
- 21. Are You eligible for:
 - a) Employment Insurance? Yes No
 - b) Workers' Compensation? Yes No
- 22. If in force group disability insurance is to be continued
 - a) is Group/Association Offset Amendment applied for? Yes No
 - b) is the group benefit taxable? Yes No

23. REVOCABLE BENEFICIARY AND/OR BENEFIT RECIPIENT DESIGNATION

The revocable beneficiary designation applies **only** to disability policies that contain the "Survivor Benefit" and/or the "Accidental Death and Dismemberment Benefit" rider.

Beneficiary _____ Equally or survivors (if any) _____ Relationship _____ Birthdate (DD/MM/YYYY) _____

The benefit Recipient designation applies **only** to Critical Illness policies. Return of Premium benefits are payable to the Proposed Owner. Critical Illness benefits will be paid to the Proposed Insured unless the Proposed Owner designates a different Recipient below.

Benefit Recipient _____ Equally or survivors (if any) _____ Relationship _____ Birthdate (DD/MM/YYYY) _____

All Recipient designations are revocable except in Quebec where the designation of a legally married spouse of the owner is irrevocable unless expressly stated to be revocable by checking the following box Revocable.

PART 2: MEDICAL HISTORY (You/Your refers to the Proposed Insured.)

1. Present Height _____ Weight _____ Name of Proposed Insured: _____
2. Has weight changed within the past year? Yes No If "Yes", indicate weight gained _____ or lost _____ .
3. Are You presently under observation or treatment, therapy, counselling or taking medication? Yes No
If "Yes", give details _____
4. Name(s), complete address(es) and phone number(s), including area code of attending physician(s) or health care facility(ies).
If none, write "none".
5. Date and reason for last consultation with a physician. _____
Result? _____
6. Is this Your regular personal physician? Yes No
If "No", provide complete name, complete address and phone number, including area code of Your personal physician.

MEDICAL DETAILS Circle appropriate concern and give details of "Yes" on Page 4.

7. Have You:
- a. Used tobacco products, including smoking cessation therapy **within the past 12 months?** If yes, please provide details (eg. cigars or cigarettes and number smoked per week or details of smoking cessation therapy) Yes No
 - b. Used or smoked marijuana **within the past 12 months?** If yes, please provide details as to when last used and frequency of use. Yes No
 - c. Ever been advised to quit smoking for health reasons? Yes No
 - d. Ever sought or received advice or treatment for the use of habit forming drugs, prescribed or non-prescribed, or used cocaine, barbiturates, marijuana, or any narcotic or habit forming drug? Yes No
If "Yes", please complete Drug Questionnaire.
 - e. Ever had a transfusion of blood or blood products? Yes No
8. Do You consume alcoholic beverages? Yes No
If "Yes":
- a. Indicate weekly quantity and type _____
 - b. Have You ever sought or received advice or treatment for or been charged with or convicted of any offence relating to alcohol use, or used alcohol excessively? Yes No
If "Yes", please complete Alcohol Questionnaire.
9. **Have You ever had any known indication of or been treated for:**
- a. Acquired immune deficiency syndrome, AIDS related complex or AIDS related conditions or tested positive for antibodies to the AIDS virus? Yes No
 - b. Any disease or disorder of eyes, ears, nose or throat (including loss of speech)? Yes No
 - c. Chest pain, heart attack, angina, abnormal ECG, irregular pulse, heart murmur, high blood pressure, high cholesterol, peripheral vascular disease or any disease or disorder of the heart, circulatory system or blood? Yes No
 - d. Kidney stone, albumin, pus, blood or sugar in urine, or any disease or disorder of the kidneys, urinary tract, bladder, prostate, or genital organs? Yes No
 - e. Stroke, transient ischemic attack (TIA), cognitive impairment, memory loss, headaches, Parkinson's Disease, Alzheimer's Disease, Motor Neuron Disease, fainting spells, dizziness, seizures, epilepsy, paralysis, multiple sclerosis, muscle weakness, numbness or tingling of the limbs or any disease or disorder of the brain or nervous system? If fainting spells or epilepsy, **please complete Loss of Consciousness Questionnaire.** Yes No
 - f. Anxiety, depression, nervousness, stress, fatigue, burnout, or other emotional disorder? Yes No
If "Yes", please complete Nervous Disorder Questionnaire.
 - g. A psychiatric disorder, mental disorder or psychosis or ever attempt suicide? Yes No
If "Yes", please complete Nervous Disorder Questionnaire.
 - h. Chronic Fatigue, Chronic Fatigue Syndrome, Epstein-Barr Virus or Myalgic Encephalomyelitis? Yes No
 - i. A tumour, cancer, polyp, or other growth, any disorder of the skin or lymph glands, blood disorder or any other form of malignant disease? Yes No
 - j. Rheumatic fever, rheumatism, syphilis, gout, arthritis, lupus, thyroid disease or diabetes, or other glandular disease or disorder? **If diabetic, please complete Diabetes Questionnaire.** Yes No
 - k. Allergies, environmental hypersensitivity or illness? Yes No
 - l. Any disease or disorder of the reproductive organs or breast including lumps, cysts, unusual discharge, other physical changes, abnormal mammogram findings or biopsy? Yes No
 - m. Any amputation or deformity, hernia or rupture, hemorrhoids or varicose veins? Yes No
 - n. Any disease or disorder of the hip, ankle, knee, wrist, elbow, shoulder, hands, feet or any other joint? Yes No
Right or left? (Circle one) **If "Yes", which joint** _____

Question 9 continued on next page

AGREEMENT

RBC Life Insurance Company is herein referred to as "the Company"

It is understood and agreed as follows:

1. I have read the statements and answers recorded in Parts 1 & 2. They are true and complete and correctly recorded. They will become part of this Application and any policy(ies) issued. I understand that false or incomplete answers to any question will affect the coverage and benefits available under the policy, and may mean that there will be no coverage and may result in legal action.
2. I will discontinue any policy(ies) shown to be discontinued immediately upon delivery to me of my policy(ies) issued by the Company as a result of this Application. The Company will rely on such answers in determining the amount, if any, of insurance it will issue. If any policy(ies) shown to be discontinued is(are) not discontinued, the policy(ies) issued by the Company as a result of this Application shall be void.
3. I understand that no agent or broker can authorize or approve of inaccurate or incomplete answers to the questions in this Application, or decide on any issue of insurability, or waive any of the Company's rights or responsibilities or make any changes to the policy or the rights and obligations stated in it. The Company will not be bound by any statement made to any agent or producer which is not recorded in this application.
4. The Company has the right to require medical exams and tests to determine insurability.
5. The insurance applied for will take effect only if and when: the policy actually has been delivered to the Proposed Owner, any and all conditions for delivery of the policy to the Proposed Owner have been satisfied completely and there has been no change in the insurability of the Proposed Insured. The only exception to this is provided in the Conditional Insurance Agreement and Receipt if the premium is paid in advance. I will immediately advise the Company of any changes in the answers to the questions in this Application.
6. The Company is authorized to obtain an investigative consumer report on me.
7. Acceptance by the Proposed Owner of any policy issued as a result of this Application will ratify any changes.
8. I hereby acknowledge receipt of Pre-Notice form describing Medical Information Bureau procedures.
9. A photostatic copy of the Application will not be automatically included in the policy (except in the Province of Quebec, in accordance with provincial law). A photostatic copy of the Application will be made available upon request.
10. Any policy(ies) issued by the Company as a result of this Application will provide coverage only for critical illness due directly to: (a) any accidental bodily injury sustained or disease or sickness which first manifests itself after delivery of the policy and while the policy is in force; and (b) unless specifically excluded, any accidental bodily injury sustained or disease or sickness which first manifests itself before delivery of the policy or before the policy is in force if the Proposed Insured has fully and accurately advised the Company, on this Application or otherwise in writing, prior to delivery of the policy, of all information known or reasonably available to the Proposed Insured regarding the injury, disease or sickness, including all signs, symptoms or other manifestations.
11. Delivery of any policy issued with an amendment form is conditional upon execution of the unaltered form by me and return to, and receipt by the Company, failing which the policy will not take effect.
12. I understand that the Company will create and maintain at their office, a file for the purposes of this application and any subsequent claim. Only the employees, mandataries or agents responsible for such purposes will have access to it. I am entitled to consult the personal information contained in this file and where applicable, have it rectified, by formulating a written request to the Company.

This application will form part of any insurance contract issued. The contract will be of utmost good faith, based upon the statements contained in this Application. I am responsible for the accuracy of the statements and answers even if I have not read them. Before signing, I have verified that all answers are correct and complete and that I have initialed any changes to those answers. Inaccurate answers to any questions may affect my eligibility for coverage and/or benefits.

I have read, understood and agree with the terms of the Conditional Insurance Agreement and Receipt (applicable only if Minimum Payment has been properly made and the Receipt properly detached from the Application).

CRITICAL ILLNESS APPLICATIONS ONLY

If a premium payment is currently being made, the Owner has received the **Receipt**, and has read, understood and agreed to all its terms, including the maximum Conditional Insuring amount of \$250,000 for the Proposed Insured, and the Critical Illness Insured Conditions. Further, the Owner understands and agrees that the Receipt and Conditional Insurance Provisions of the Basic Application are not applicable for Critical Illness Recovery Plan.

Please see reverse for required signatures

ALL APPLICATIONS

Signed at: _____ Date : _____
(City/Province) (MM/DD/YYYY)

Proposed Insured (Signature): X _____

Proposed Owner (Signature): X _____

Note: If policy is to be owned by a corporation, this Application must be signed by an Officer of the Company, other than the Proposed Insured.

WITNESS

Name (Please Print): _____ Signature: X _____

Address : _____ Signed at: _____
(City/Province)

Telephone : _____ Date : _____
(MM/DD/YYYY)

Note: Witness cannot be related to the Proposed Insured or Proposed Owner. Witness may be the Producer, if present.

PART 3: COVERAGE APPLIED FOR AND PREMIUM INFORMATION

Complete Appropriate Sections

A. COVERAGE APPLIED FOR

Complete the following: Occupation Class _____

Policy Name(s)	1.		2.		3.	
Monthly indemnity	BASE	AMI	BASE	AMI	BASE	AMI
Elimination period						
Benefit period						

Additional benefits applied for: _____

Is this application part of a Wage Loss Replacement Plan? Yes No If "Yes", please complete Wage Loss Replacement Amendment W692. (page 15)

CRITICAL ILLNESS COVERAGE APPLIED FOR

Plan	Supplementary Benefits
<input type="checkbox"/> Non-cancellable 10 Year Term to age 75	Disability Waiver of Premium Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/>
<input type="checkbox"/> Guaranteed renewable to age 65	Disability Waiver of Premium Rider <input type="checkbox"/> Functional Dependence Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry/Surrender Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>
<input type="checkbox"/> Guaranteed renewable to age 75	Disability Waiver of Premium Rider <input type="checkbox"/> Functional Dependence Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry/Surrender Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>
<input type="checkbox"/> Guaranteed renewable to age 75 , paid up at age 65	Disability Waiver of Premium Rider <input type="checkbox"/> Functional Dependence Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>
<input type="checkbox"/> Non-cancellable to age 75	Disability Waiver of Premium Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>
<input type="checkbox"/> Non-cancellable to age 75 , paid up at age 65	Disability Waiver of Premium Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>
<input type="checkbox"/> Non-cancellable to age 100	Disability Waiver of Premium Rider <input type="checkbox"/> Return of Premium on Death Rider <input type="checkbox"/> Return of Premium on Expiry/Surrender Rider <input type="checkbox"/> Scheduled Increase Benefit Rider <input type="checkbox"/>

B. IF APPLYING FOR BUSINESS LOAN PROTECTOR Describe purpose and amount of loan.
If loan exceeds \$50,000, attach a letter from the lending financial institution.

C. OWNERSHIP Complete if the owner is to be other than the Proposed Insured. This must be completed for Disability Buy Sell and Key Person Insurance, or if Wage Loss Replacement Plan. Complete for Business Overhead, Business Loan Insurance and Critical Illness if owner is not the Proposed Insured.

Proposed Owner _____ Address _____

Contingent Owner _____ Address _____

To Whom should correspondence be sent? _____

D. PREMIUM INFORMATION

If either of Part 2, 11a or b is answered "Yes", the producer may not accept an initial deposit with the application and the Receipt and Conditional Insurance Agreement is void.

1. Initial deposit Collected? Yes No (COD)
If initial deposit collected, it is in exchange for the Receipt and Conditional Insurance Agreement. Make cheque payable to **RBC Life Insurance Company**.

2. Complete the following. Provide deposit amount for each plan requested.

PLAN	DEPOSIT	PLAN	DEPOSIT	PLAN	DEPOSIT	PLAN	DEPOSIT
_____	_____	_____	_____	_____	_____	_____	_____

If deposit cheque is for more than one applicant, please provide name(s).

3. **PREMIUM MODE** (Check one each of a, b, & c, and give Group # if applicable.)

a. PAC/INSUREmatic (complete authorization form) b. Monthly Annual Semi-annual

c. Standard Select/Risk or Salary Allotment/Maximizer/Performer # _____

Large Case Discount # _____ 5% 10% 15% (circle one).

New group? Yes No Existing group? Yes No List members in Producer remarks if no transmittal attached.

E. PREMIUM NOTICES AUTHORIZATION AND AGREEMENT
(Complete if someone other than the owner/insured is to receive premium notices)

X _____, owner of the insurance policy, hereby authorize the Company to send all premium notices, premium lapse notices or pay any premium refunds to and accept premium payments from:

PREMIUM PAYOR NAME AND ADDRESS

COMPLETE IN ALL CASES - AUTHORIZATION

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files, which contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or the persons to whom I have granted access, in writing, or to any other person authorized by law.

I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my Application.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income or employment that is relevant to this Application, which they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also Medical Information Bureau Inc. (M.I.B.); and also to any other person, agency, credit bureau or institution having information, records or data regarding me.

I understand that any information, records or data received by the Company pursuant to this authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the Medical Information Bureau Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ this _____ day of _____ year _____
(Province/City) (Month)

Signature of Proposed Insured

Signature of Witness

COMPLETE IN ALL CASES - AUTHORIZATION

I understand and authorize the Company (RBC Life Insurance Company and its reinsurers) to conduct such investigation as is necessary and to gather personal information concerning me. I understand that the Company will create and maintain files, which contain personal information concerning me. I also understand that access to personal information concerning me will be limited to the employees of, and other persons engaged by, the Company in performance of their duties, or the persons to whom I have granted access, in writing, or to any other person authorized by law.

I further understand that, except when the Company can and does lawfully restrict my access to personal information concerning me, I will be permitted to review copies of documents containing said personal information in the possession of the Company, upon paying reasonable copying charges. I further understand that I will be permitted to request access to such documentation and to have any errors in the personal information noted and corrected by formulating a written request to the Company mailed to the employee who is handling my Application.

I authorize and direct the persons, institutions and organizations listed below to disclose and provide to the Company any information, records or other data regarding me, my medical history or treatment, or my past and present income or employment that is relevant to this Application, which they have in their possession or control.

Persons to whom this Authorization applies: Any licensed physician, nurse, counselor, psychologist, social worker, therapist, pharmacist, physiotherapist, chiropractor, or other rehabilitation professional or other health care practitioner; and also any hospital, clinic, pharmacy, or other medical facility or provider of health care or treatment; and also the provincial health insurance plan, any insurance or reinsurance company or other financial institution; and also my employer or former employers; and also any federal or provincial government department or organization, including the federal or provincial income tax authorities and provincial motor vehicle divisions; and also Medical Information Bureau Inc. (M.I.B.); and also to any other person, agency, credit bureau or institution having information, records or data regarding me.

I understand that any information, records or data received by the Company pursuant to this authorization, both medical and non-medical, will be used for the assessment of insurance risk for underwriting purposes and for the purpose of evaluating any claim for benefits or to assess the validity of the policy as issued.

To the extent reasonably necessary for those purposes, I authorize the Company to disclose any of the said information, records or data received: to the Medical Information Bureau Inc., and to other insurance companies or any reinsurer.

This authorization is valid until revoked by me in writing.

A photocopy of this authorization, as executed by me, will be as valid as the original.

Dated at _____ this _____ day of _____ year _____
(Province/City) (Month)

Signature of Proposed Insured

Signature of Witness

Pre-Authorized Chequing (PAC) Agreement

Ensure you read & understand the section "Your Privacy Matters to Us"

The Payor(s) named below agrees that:

1. (a) RBC Life Insurance Company (RBC Insurance) is authorized to make scheduled withdrawals to pay the premium for this policy or policies, against the account at the financial institution below, or any other financial institution that the Payor may later designate, in accordance with the rules of the Canadian Payment Association ("CPA").
(b) such withdrawals will be on dates and in amounts in accordance with the premium schedule set out in this policy or policies,
(c) if the amount of withdrawal should vary, pre-notification by RBC Insurance is waived,
(d) the financial institution indicated below is authorized now or of any subsequent time to honour any requests made by RBC Insurance to withdraw from the account indicated below, including a representation or redraw within 30 days should any withdrawal not clear the account,
(e) unless otherwise indicated in the Special Requests section below, such withdrawals shall be dated on the day of the month on which the premium is due under the policy or, if more than one policy is included in this Agreement, the withdrawals shall be dated to coincide with the existing policy(ies),
(f) notification of any change to the account information provided below, shall be given to RBC Insurance by the Payor 5 days prior to the next scheduled withdrawal. I/We agree that from time to time I/we may authorize RBC Insurance to deduct such payments from another account upon my/our oral or written instructions,
(g) this Agreement will terminate in respect of all policies included in it upon 10 days written notice by RBC Insurance or by the Payor,
(h) A PAC may be disputed by the undersigned under the following conditions:
 - i) If the PAC was not drawn in accordance with this Agreement; or
 - ii) If this Agreement was revoked.

In the event that either (i) or (ii) applies, the Payor agrees to contact RBC Insurance. If a satisfactory resolution cannot be achieved between the Payor and RBC Insurance, then in accordance with CPA rules, in order to be reimbursed, the undersigned acknowledge(s) that a declaration to the effect that either (i) or (ii) took place, must be completed and presented to the branch holding the account up to and including 90 calendar days in the case of a personal PAC (or up to and including 10 business days in the case of a business PAC), after the date on which the PAC in dispute was posted to the account below.

I/We acknowledge that a claim on the basis that this agreement was revoked, or any other reason, is a matter to be resolved solely between me/us and RBC Insurance when disputing any PAC after the 90 calendar days in the case of a personal PAC (or up to and including 10 business days in the case of a business PAC).

(i) the names and signatures of all persons required to authorize withdrawals from the account indicated are included below.

2. Add to existing PAC with policy number(s) _____

3. Special Requests (withdrawals are limited between the 1st - 28th of the month) _____

Bank Information:

Please attach a specimen cheque marked void (a line of credit account cannot be used).

Name of Bank or Financial Institution	Transit Number	Bank Number	Account Number
_____	_____	_____	_____

Address _____

City	Province	Postal Code
_____	_____	_____

Dated at _____ this _____ day of _____
(City/Province) (Month/Year)

_____	_____
Print Name of Payor (Account Holder)	Print Name of Second Payor (Account Holder) (if any)

_____	_____
Signature of Payor	Signature of Second Payer (if any)

RECEIPT AND CONDITIONAL INSURANCE AGREEMENT IF MINIMUM PAYMENT IS MADE LEAVE THIS RECEIPT WITH PROPOSED INSURED

Receipt must **NOT** be detached from Application without Minimum Payment* by personal cheque or money order (not pre-authorized cheque or debit) at time of application.

Cheque or money order must be made payable to **RBC Life Insurance Company**.

Do not make cheque payable to agent or producer or leave payee blank.

No agent or producer is authorized to take payment or issue a receipt if either question 11a or b of "Part 2: Medical History" of the Application is answered "Yes" or left blank. No agent or producer is authorized to alter or waive any condition or other provision of this Agreement.

Received a payment of \$ _____ on _____ (date) with the Application for insurance on behalf of

_____ (the Proposed Insured).

DEFINITIONS

For the purpose of this Conditional Insurance Agreement:

"You" means the Proposed Insured on the Application.

"We", "Us" and "Our" mean the Company.

"Minimum Payment" is an initial deposit of one month's premium for monthly premium mode and 10 percent of the annual premium for all other modes.

"Effective Date" means the later of the following:

- (a) The date We receive the Minimum Payment; or,
- (b) The date of completion of the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; or,
- (c) The date of issue requested by the Proposed Owner at the time of application.

CONDITIONAL INSURANCE

We accept this payment and will insure You commencing on the Effective Date subject to all of the following

CONDITIONS PRECEDENT:

- (a) The amount of the payment is equal to or greater than the Minimum Payment; and
- (b) Completion of the Application and all medical examinations and supplementary tests which We may require according to Our underwriting guidelines and practices; and,
- (c) You are insurable, according to Our underwriting guidelines and practices, under any policy currently offered by Us; and,
- (d) The Producer Declaration has been signed by a licensed producer or agent.

We will not insure You under this Agreement, in any event, if:

- (a) Either question 11a or b of "Part 2: Medical History" of the Application is answered "Yes" or left blank; or,
- (b) There is any material misrepresentation on the Application; or,
- (c) Death is by suicide; or,
- (d) You are not insurable according to Our underwriting guidelines and practices under any policy currently offered by Us.

If conditional insurance becomes effective it will be exactly as applied for only if, according to Our underwriting guidelines and practices, You are insurable for the policy and amount exactly as applied for, at our standard rate of premium, with no exclusions, limitations, reductions or other modifications. Otherwise, the conditional insurance will be the modified policy under which You would have been insurable on the Effective Date according to Our underwriting guidelines and practices.

However, in no event will We be liable under this Agreement for accidental death benefits, including any insurance currently in force or pending with Us, in excess of \$100,000.

TERMINATION

If conditional insurance becomes effective it will terminate on the earliest of the following:

- (a) The date that any policy issued as a result of the Application is delivered to You and comes into effect; or,
- (b) 90 days from the Effective Date; or,
- (c) The date that We write to advise that We are unable to approve the issuance of a policy.

RETURN OF PAYMENT

If conditional insurance does not become effective, Our liability will be limited to return of the payment tendered with this Agreement.

**APPLICATION FOR CONDITIONAL INSURANCE ON
CRITICAL ILLNESS APPLICATIONS**
(NOT AVAILABLE FOR INFORMAL INQUIRIES)
DO NOT DETACH

To be answered by the Proposed Insured

- | | Yes | No |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Have You ever been treated for or had any indication of heart or circulatory disease, Parkinson's Disease, Alzheimer's Disease, Huntington's Chorea, heart attack, chest pain, abnormal ECG, stroke, transient ischemic attack (TIA), multiple sclerosis, paralysis, blindness, deafness, diabetes, elevated blood pressure, chronic kidney, liver or lung disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. To the best of Your knowledge and belief, have You had any symptoms of or treatment for cancer or tumour, AIDS, ARC or HIV infections? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have You had any symptoms of or treatment for any medical condition that resulted in hospitalization (other than normal childbirth) within the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have You been absent from work for more than 7 days within the last 6 months because of sickness or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are You over age 65? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has any application for insurance on Your life ever been rated, declined or modified in any way? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are You aware of any symptoms for which You have not yet sought treatment or for which treatment is planned or pending? | <input type="checkbox"/> | <input type="checkbox"/> |

THE CONDITIONAL INSURANCE AGREEMENT WILL ONLY BE GIVEN IF ALL OF THE ABOVE QUESTIONS ARE ANSWERED "NO" AND WILL ONLY BE VALID AND ENFORCEABLE IF SUCH ANSWERS ARE TRUE.

An applicant is only eligible to be considered for conditional insurance where the total amount of insurance under all plans being applied for from the Company is \$250,000.00 or less and the Proposed Insured is under the age of 65 years. When conditional insurance is available and the Company agrees to grant conditional insurance, the amount of such conditional insurance provided will be the aggregate of all amounts applied for shown on the Application, but such conditional insurance shall not exceed the amount of \$250,000 in cases where the aggregate amount applied for exceeds that amount. This Application for Conditional Insurance may be completed only at the time of completion of the insurance Application and payment of the first premium must be made on the same date. If the Proposed Insured dies or suffers a Critical Illness by an act of self destruction, whether intentional or not, the Company's liability is limited to a refund of the payment made.

I agree to the terms and conditions of the Conditional Insurance Agreement as set out below.

Date at _____ this _____ day of _____
CITY/PROVINCE DAY MONTH YEAR

X _____ X _____
SIGNATURE OF OWNER (IF OTHER THAN PROPOSED INSURED) SIGNATURE OF PROPOSED INSURED

CICIA (05/04)

**CONDITIONAL INSURANCE AGREEMENT AND RECEIPT ON
CRITICAL ILLNESS APPLICATIONS**

(TO BE LEFT WITH INSURED IF DEPOSIT SUBMITTED AND APPLICATION FOR CONDITIONAL INSURANCE IS COMPLETED)

The Company agrees to provide conditional insurance on the Proposed Insured named in the Application made on the date of this Agreement payable only for a single occurrence of one of the Critical Illnesses defined in the contract to the Beneficiary named in the Application, subject to the conditions set out below.

TERMINATION OF CONDITIONAL INSURANCE

1. Conditional insurance terminates automatically when a Policy providing insurance as a result of the Application becomes effective.
2. The Company may terminate conditional insurance by mailing a notice to that effect addressed to the Owner (termination being effective on mailing), in which event any money paid will be refunded. Termination shall take place notwithstanding that such refund has not yet been received by the Proposed Insured.
3. In any event, conditional insurance will terminate automatically on the expiration of ninety days from the date of this Agreement.

CONDITIONS

1. There will be conditional insurance available on the Proposed Insured only, and only if he or she is under the age of 65 years on the date of this Agreement and if the total amount of insurance being applied for is \$250,000.00 or less.
2. Insurance under only one Conditional Insurance Agreement can be in effect on the Proposed Insured. If more than one Application for Conditional Insurance is submitted, effect will be given only to the one with the higher face amount.
3. Conditional Insurance is not provided for any Disability Insurance or any supplementary benefit.
4. At least 10% of the aggregate yearly premium for the amount of the Basic Plan or one month's premium for monthly premium mode must have been paid to the Company at the time of completion of the Application.

LIMITATIONS

1. No payment will be made under this Agreement for any diagnosis of cancer.
2. No payment will be made under this Agreement if death occurs within 30 days of the diagnosis of the defined critical illness.
3. If the Proposed Insured dies or suffers a covered critical illness as a result of an act of self-destruction, the Company's liability is limited to a refund of the payment made. An act of self-destruction occurs when the Insured, whether sane or insane, takes or attempts to take his/her own life or inflicts injuries on his/her own person, and the death or injury of the Insured results directly or indirectly from, or is in any manner or degree associated with, or occasioned by, the actions described previously, no matter when death or injury occurs.
4. There is no coverage under this Agreement if the cheque submitted as payment is not honoured on presentation.
5. No person has the authority to modify or waive any requirements of conditions of this Agreement.

It is acknowledged that the sum of \$ _____ was paid to the Company at the time of the completion of this Application.

Date _____ Signature of Producer X _____
(MM/DD/YYYY)

Detach and give to Proposed Insured

**Consumer Fact Sheet
PRE-NOTICE**

Information regarding your insurability and claims will be treated as confidential. The Company or our reinsurers may however, make a brief report thereon to Medical Information Bureau (MIB) Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB file, you may contact MIB, and seek a correction.

The address of MIB's information office is: Medical Information Bureau, 330 University Avenue, Toronto, Ontario, Canada, M5G 1R7. Telephone No. 416-597-0590. Web site: <http://www.mib.com> We may also release information in our files to our reinsurers and/or other life insurance companies to whom you may apply for life or disability insurance, or to whom a claim for benefits may be submitted.

Personal History Interview (PHI)

As part of the underwriting process. You may be asked to respond to a telephone interview. The Personal History Interview (PHI) is conducted by specially trained interviewers. The interview will take approximately five minutes. Since we want to conduct the interview at a time most convenient for you, we ask you on the application whether you wish to be contacted at home or at work and the best time to call.

The questions asked by the interviewer amplify the information on your application for insurance. These questions relate to personal, financial and medical aspects of insurability. We also use the PHI process to gather information which may have been omitted or only partially explained.

Because of the nature of the information obtained, the PHI interview will only be conducted directly with you.

Any information obtained during the PHI interview will be kept strictly confidential and will not be released to anyone without your written consent.

Your co-operation in this process is greatly appreciated and enables us to provide you with the best quality underwriting.

Disclosure Statement for the Province of British Columbia

Pursuant to S.90 of the Financial Institutions Act of British Columbia, the financial product you are being offered is supplied by RBC Life Insurance Company, a company licensed to carry on business in British Columbia.

In relation to any application you may make for the acquisition of life insurance, annuities or other financial products:

- I am acting as a licensed insurance representative on behalf of this company;
I will be entitled to receive commission from the company on successful completion of this transaction. This commission may take the form of an acquisition commission and/or an on-going service commission; and
- there is no condition associated with this transaction requiring that you must transact additional or other business with either myself or the company.

Dated at _____ this _____ day of _____ Year _____
City/Province

Signature of Representative

Dated at _____ this _____ day of _____ Year _____
City/Province

Signature of Representative



1122 International Boulevard, P.O. Box 5044, Burlington, Ontario L7R 4C1 • 905-319-9501

WAGE LOSS REPLACEMENT PLAN - AMENDMENT FORM

(Not to be used for Bridge Series)

Proposed Insured: _____ File: _____

The Owner and the Insured hereby acknowledge and agree that the individual disability insurance policy for which they are applying, or have applied for, is intended to form part of a "Wage Loss Replacement Plan" which either already exists or will be established immediately by the Owner of the Policy. All premiums will be paid solely and directly by the Owner. Any claim benefits (other than waiver of premium) will be paid to the Insured as taxable claim benefits.

The Owner and the Insured acknowledge and understand that in the event that a valid Wage Loss Replacement Plan acceptable to Canada Customs and Revenue Agency is not established and maintained;

- (a) The premiums paid by the Owner may be disallowed retroactively by Canada Customs and Revenue Agency as a tax deductible expense and,**
- (b) Canada Customs and Revenue Agency may require the Insured, retroactively, to include the amount of the premiums as a taxable payroll benefit in calculating his or her personal income taxes.**

The Owner and the Insured specifically acknowledge and agree that they alone shall be solely and completely responsible for establishing and continuing to maintain a valid Wage Loss Replacement Plan acceptable to Canada Customs and Revenue Agency. The Owner and the Insured acknowledge and agree that they do not rely upon any tax or other advice whatsoever from the Company or its employees regarding the validity of the Wage Loss Replacement Plan. The Owner and the Insured specifically agree that the Company and its employees shall not be liable in any way, for tax or other advice received from any broker or for tax arrears or otherwise, resulting from termination or invalidity of the Wage Loss Replacement Plan.

The Owner and the Insured specifically agree that, in the event that a valid Wage Loss Replacement Plan is not established or, if established, it terminates or ceases to be valid or acceptable to Canada Customs and Revenue Agency, or in the event that the Insured ceases for any reason to be a member of the Plan:

- (a) The Owner and the Insured immediately will notify the Company, in writing, at its office, located at P.O. Box 5044, Burlington, Ontario L7R 4C1;**
- (b) Effective as of the date of termination or invalidity of the Plan or the date that the Insured ceases to be a member, whichever occurs earlier, the monthly benefit provided by the Policy shall be reduced to the amount for which the Insured would have qualified based upon the Company's non-taxable issue limits including eligibility for EI disability benefits that are currently in effect or that were in effect on the Date of Issue of the Policy, whichever is more favourable to the Insured.**
- (c) The Insured immediately shall repay to the Company any and all excess claim benefits paid by the Company prior to its receipt of notification that a valid Plan was not established or terminated or ceased to be valid or that the Insured ceased to be a member, whichever occurred earlier; and,**
- (d) The Policy premium will be reduced to the amount that the Company would have required for the reduced monthly benefit referred to in (b) above. The Company will refund to the Owner any excess premiums paid by the Owner.**

The Amendment will apply notwithstanding any Policy provision to the contrary. All other provisions of the Policy will remain the same.

This Amendment will form part of the Policy. The effective date of this Amendment shall be the same as the Date of Issue of the Policy.

I agree to this Amendment:

Insured Signature: X _____

Witness Signature: X _____

Owner Signature: X _____

Witness Signature: X _____

Dated _____

at _____

(MM/DD/YYYY)



BACK & NECK DISORDER QUESTIONNAIRE

Name of Proposed Insured: _____ Application/Policy No: _____

1. Have you ever had any type of back or neck pain or discomfort or any other neck or back related symptom or complaint or have you ever had any indication of or been treated for any disease or disorder of the back or neck?
Yes No If yes, please answer all questions below.

2. Specify area involved: Neck (cervical) Upper/middle (thoracic) Low (lumbar – waist and below)
If more than one area is involved, please complete a separate questionnaire for each area affected.

The following details relate to the Neck (cervical) Upper/middle (thoracic) Low (lumbar – waist & below)

3. a) How many episodes of back or neck pain or discomfort or related symptoms have you had?
b) Date of first episode:
c) Describe symptoms of the first episode:
d) How long did the symptoms of the first episode last?
e) What was the final diagnosis?
f) Date of the last episode:
g) Describe the symptoms of the last episode:
h) How long did the symptoms of the last episode last?
i) What was the final diagnosis for the last episode?
j) What was the longest duration of symptoms for all episodes?

4. Have you ever had any back or neck related numbness or tingling or radiation of pain to other parts of your body?
Yes No If yes, indicate date(s) and area(s) involved:

5. a) Have any diagnostic tests been completed? Yes No If yes, specify type(s), date(s), and results:
X-ray studies
CT scan
MRI
Bone scan
Other (specify)

b) Have any tests or investigations been recommended? Yes No If yes, specify nature of test(s) or investigation(s) and date(s) scheduled:

6. a) Have you ever had epidural steroid injections or treatment at a pain clinic? Yes No
If yes, indicate date(s) and name and address of doctor(s) or medical facility(ies):

b) Have you ever had chiropractic manipulation or treatment? Yes No If yes, provide details:
1. Date(s), frequency and duration of treatment:
2. Date of last chiropractic consultation:
3. Name and address of chiropractor(s):

c) Have you ever had physical therapy or any other form of treatment for this condition? Yes No
If yes, indicate type(s), date(s) and duration of treatment, name and address of provider(s):

7. Have you ever been prescribed medication for any back or neck condition or symptom? Yes No
If yes, provide details including name(s) of medication(s) and date(s) prescribed: _____

8. Have you ever been hospitalized for any back or neck condition or symptom? Yes No
If yes, indicate date(s), duration, reason, name and address of hospital(s): _____

9. Have you been told you may need surgery at some time in the future? Yes No
If yes: a) Specify type of surgery: _____
b) Has surgery been scheduled? If yes specify date: _____

10. Have you ever lost any time from work due to back or neck related symptoms? Yes No
If yes, provide details including dates and duration of time off work: _____

11. Have your job duties or daily activities ever been restricted or modified in any way because of this condition?
 Yes No **If yes, describe restrictions, modifications or limitations:** _____

12. Do you have any ongoing symptoms? Yes No
If yes, describe symptoms: _____

If no, how long have you been completely free of any neck or back related symptoms? _____

13. Other than those already declared, please provide the full names and addresses of all doctors, health care professionals, hospitals or health care facilities consulted for this condition and the dates of consultations:

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: _____ **Date:** _____

Day/Month/Year



NERVOUS DISORDER QUESTIONNAIRE

Name of Proposed Insured: _____ Application/Policy No: _____

1. Please specify/describe all current and past symptoms, history or diagnosis of (check off appropriate boxes):

- Stress, Anxiety, Depression, Burn out, Insomnia, Dysthymia, Phobia(s), Other (describe)
Fatigue, exhaustion, Chronic Fatigue, Major Depression, Panic Attack(s), Adjustment Disorder, Bulimia, Anorexia Nervosa
Marriage/familycounselling, Attention Deficit Disorder, Concentration problems, Memory problems, Agoraphobia, Post T traumatic Stress, Counselling for (specify)
Bipolar Disorder, Suicidal thoughts or attempts, Psychosis/hallucinations, Anger management problems, Seasonal Affective Disorder, Generalized Anxiety Disorder

2. Have you experienced any symptoms within the last 12 months? Yes No

If yes: Describe all symptoms: _____

If no: How long have you been completely symptom-free? _____

3. a) Date of onset of your initial symptoms: _____

b) Cause(s) of symptoms: _____

c) How many separate occurrences or episodes of symptoms have you had? _____

d) What was the duration of each occurrence or episode? _____

4. Has your physician given you a diagnosis? Yes No If yes, provide full details, including the date a diagnosis was given: _____

5. Have you taken medication, prescribed or non-prescribed, or received treatment in the past 12 months? Yes No If yes, provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment and the date treatment was first recommended: _____

6. What other medication(s) or treatment has been prescribed in the past? Provide the name of all medication(s), the date medication(s) was first prescribed, details of all treatment, the date treatment was first recommended, and the date and reason medication(s) or treatment was discontinued: _____

7. Have you been referred to a psychiatrist or psychologist for this condition? Yes No **If yes**, provide full names(s) and address(es) of those consulted, date of first consultation, frequency of follow-up visits and date of the last consultation.

8. Have you ever consulted an emergency room or been hospitalized for this condition? Yes No **If yes**, advise date(s), reason(s) and name and address of hospital(s): _____

9. Have you ever had any suicidal thoughts or attempts? Yes No **If yes**, provide dates and details:

10. Have you ever lost any time from work due to this condition? Yes No **If yes**, provide details including dates and duration of time off work: _____

11. Have your job duties or daily activities ever been restricted or modified in any way because of this condition? Yes No **If yes**, describe restrictions, modifications or limitations: _____

12. Other than those already declared, please provide the names and addresses of all physicians, psychiatrists, psychologists, counsellors, mental health care providers, other health care practitioners, hospitals or facilities consulted for this condition and include details and duration of treatment: _____

I declare that the answers I have given on this questionnaire are true and complete and shall form part of my application.

Signature of Proposed Insured: _____ **Date:** _____
(Day/Month/Year)



CRITICAL ILLNESS FINANCIAL QUESTIONNAIRE

Proposed Insured: _____ File: _____

1. Amount of Mortgage on personal residence or cottage \$ _____

2. If the Proposed Insured is not self-supporting: What is the gross amount of the family earned income? \$ _____

If Keyperson (including Keyperson replacement or collateral coverage) or Business Loan coverage applied for, complete the following. (Amounts must be based on most recent financial results.)

3. a) Amount of Business Loan \$ _____ b) Payback term _____ yrs. c) Loan details _____

d) Purpose of Loan _____

4. a) Percentage of business owned by Proposed Insured? _____ %

b) Total Assets \$ _____

c) Total Liabilities \$ _____

d) Book Value \$ _____

e) Fair Market Value \$ _____

f) Gross Revenues \$ _____

g) Net Income after Taxes \$ _____

5. If applying for business loan coverage, are all the business owners applying for Critical Illness coverage? Yes No

If "Yes" provide percentage equity of each owner and amount of coverage in force or applied for. _____

If "No", provide reason: _____

I hereby declare that this information is true and complete and shall form part of my Application.

Date _____ (MM/DD/YYYY)

Proposed Insured Signature X _____

Producer Signature X _____

REPRESENTATIVE'S REPORT

1.	How long have you known the Proposed Insured ?	years	
2.	Were the negotiations for this Application started by: You? <input type="checkbox"/> Proposed Insured? <input type="checkbox"/> Proposed Owner(s)? <input type="checkbox"/>		
3.	The Proposed Insured may be contacted by telephone for a Personal History Interview. What is the most convenient time to contact them? Business <input type="checkbox"/> Residence <input type="checkbox"/> at _____ local time.		
4.	Have you collected money? Yes <input type="checkbox"/> No <input type="checkbox"/>		
	If yes, indicate amount collected \$ _____		Date received (mm/dd/yyyy)
5.	Do the Proposed Insured and the Proposed Owner(s) understand English or French ? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please ensure a Statement of Understanding is signed by the Proposed Insured and the Proposed Owner(s) and submitted with this application.		
6.	Back date to save age? Yes <input type="checkbox"/> No <input type="checkbox"/> (Age is calculated based on the Age Nearest on the underwriting decision date, not the application date.) Other special date required:		
7.	Evidence: The following requirements have been ordered: Blood Profile <input type="checkbox"/> ECG <input type="checkbox"/> Medical Exam <input type="checkbox"/> MVR <input type="checkbox"/> Para-medical <input type="checkbox"/> Urine-HIV <input type="checkbox"/> Other (specify) <input type="checkbox"/> Para-medical company used:		
8.	<p>Representative's Declaration: I have clearly explained the provisions and limitations of the policy being applied for and, if applicable, the Conditional Insurance Agreement, to the Proposed Insured and the Proposed Owner(s). All of the questions in the application were clearly asked of, or read by, the Proposed Insured and the Proposed Owner(s). To the best of my knowledge, they understood all of the questions. To the best of my knowledge, all of the answers and statements on the application have been fully and accurately recorded. I am not aware of any pertinent information about the Proposed Insured(s) that has not been disclosed on the application. If a policy is issued, I will deliver it to the Proposed Owner(s) only after obtaining confirmation that all conditions for delivery have been completely satisfied and there has been no change in the insurability of the Proposed Insured. I understand that I cannot modify the application, the Conditional Insurance Agreement or the terms of the policy, if issued. I have complied with my duties and obligations in regards to Advisor Disclosure, including providing an Advisor Disclosure Statement in writing to the Proposed Owner.</p>		

Date (dd/mm/yy)			
Representative's Signature			
Representative's Name			
Representative's Company Name			
Marketing Office			
Share	%	Servicing Representative Code	% Representative Code



® Registered Trademarks of Royal Bank of Canada.
RBC Insurance is a registered trademark of Royal Bank of Canada. Used under license.